agic
Arolygiaeth Gofal Iechyd Cymru

hiw
Healthcare Inspectorate Wales

Annual Report 2015-16

Mental Health Hospitals, Learning Disability and Mental Health Act Inspections

October 2017

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: **hiw@gov.wales**
Fax: 0300 062 8387
Website: **www.hiw.org.uk**

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

OGL © Crown copyright 2017 WG33197 Digital ISBN 978 1 78859 704 3

Contents

1 Executive Summary

2 Admission of patients to mental health facilities in Wales

3 What we did
- **3.1** Our role in regard to mental health
- 3.2 Using intelligence to focus our work
- 3.3 Where we visited

4 What we found

- **4.1 Inspections of mental health services**
  - Quality of patient experience
  - Delivery of safe and effective care
  - Quality of management and leadership
  - Management issues specific to the independent sector

- **4.2 Monitoring the use of the Mental Health Act**
  - Purpose of the Mental Health Act
  - How is the Act monitored in Wales
  - The Second Opinion Appointed Doctor Service

5 Conclusion and Next Steps

6 Glossary

Appendix A

1 Executive Summary

Introduction

Our mental health and learning disability inspections include both independent hospitals and mental health hospitals and community services provided by the NHS. Inspections and follow-up visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services throughout Wales. The inspections also fulfil our responsibility to monitor parts of the Mental Health Measure (2010) by reviewing individual patient care and treatment plans to ensure that patients have a Care Co-ordinator appointed and patients have a comprehensive mental health and physical health assessment. In addition, Part 4 states that every in-patient must have access to an independent mental health advocate and this is another area that HIW monitors.

Our reports provide more context to our visits and enable readers to have more in depth information regarding the setting, our findings, our recommendations and next steps. We ask all hospitals to provide an action plan outlining how and when they will achieve the requirements and/or recommendations and we monitor progress accordingly. All our reports, action plans and updated action plans are published on our website.

Our work

During 2015-16 we conducted 12 inspections of independent establishments and 4 inspections of NHS providers as well as 7 follow-up visits. We also undertook 59 Mental Health Act monitoring ward visits covering 30 hospitals, most of which were undertaken as part of our inspection programme.

In addition, for the first time we started a programme of review for the patients that were subject to Community Treatment Orders (CTO's). We undertook these visits to 3 Health Boards namely; Cwm Taf, Cardiff and the Vale and Aneurin Bevan.

During the inspection year we have issued 8 immediate assurance letters requiring a quicker assurance to some of the more urgent findings from our visits. In addition, in relation to the independent hospitals, a total of 2 non-compliance notices have been sent: this is the first stage of our enforcement process.

What we found

Inspections of mental health services

Throughout our mental health and learning disability inspection visits we have noted a number of areas of noteworthy practice, including:

- the positive rapport between patients and staff, despite staff dealing with very challenging patients;
- we observed an increase in NHS hospitals working towards and obtaining external accreditation, including Accreditation for Inpatient Mental Health Services (AIMS), Star Wards and Safewards, this is to be commended;
- multi disciplinary team working including community based staff across NHS is generally effective and, particularly in private providers, staff felt that the opinions of all professional disciplines that attended the meetings were valued and listened too;
- the level of psychology and occupational therapy input across the independent sector is noteworthy; and
- the openness of staff and patients to engage with the inspection process across both NHS and independent hospitals is generally very good.

However, we also identified a number of concerning themes for the NHS and independent hospitals during our inspections relating to delivery of physical healthcare, availability of sufficient staff with the right skills and knowledge, a lack of robust care and treatment plans, the need to keep essential policies and procedures under review.

Other specific themes identified within the NHS included: a lack of available beds, difficulties accessing psychology and occupational therapy, the need for consistent training in a variety of areas, a lack of a clear admission criteria or its disregard, and the need for robust staff supervision. Maintenance was also a significant issues with 80% of hospitals visited needing maintenance, refurbishment and replacement of equipment and furniture.

Additional issues specific for independent hospitals included a lack of documentation in relation to the responsible Individual visits and inadequate supervision records.

Monitoring the Use of the Mental Health Act

Our Mental Health Act visits did not highlight any consistent failings regarding the administration of the Act in Wales in both the NHS and independent sector.

For the first time during 2015-16 we commenced a programme of monitoring the implementation of the Act for patients in the community on Community Treatment Orders (CTOs). Throughout the health boards there are a significant number of patients detained in the community on CTOs and in some health boards there are nearly as many patients detained in the community, on CTOs, as in-patients accommodated on hospital wards.

We undertook a total of 3 visits to Cwm Taf, Cardiff and the Vale, and Aneurin Bevan health boards where we held interviews and discussions with patients, relatives, advocates and a cross section of staff involved in caring for patients. In all three reviews we found good examples of multi disciplinary team working and decision making. However, we identified issues with completion of documentation including the incorrect use of language when referring to the Act. We also noted that sometimes processes and systems affected the consistency of continuity of the care being provided. In one health board we saw that this led to delays in booking transport for patients and in another health board a lack of a unified electronic system for patient information resulted in delays transferring information between the different organisations involved in caring for patients.

We continue to find that individual Mental Health Act administration teams are struggling to undertake their role in ensuring patient safeguards are upheld, i.e. appeals against detention, provision of rights monitoring, consent to treatment safeguards. This is in the main due to a lack of resources. It is imperative that health boards and independent hospitals review the role of Mental Health Administrators to ensure that they have sufficient time to effectively undertake all aspects of the role.

2 Admission of patients to mental health facilities in Wales[1]

In 2015-16, the total number of admissions to mental health facilities in Wales was 9,570. This was a decrease of 192 (2 per cent) compared with 2014-15.

People who are compulsorily admitted to hospital are called ‘formal’ patients and people who are admitted to hospital when they are unwell without the use of compulsory powers are called ‘informal’ patients.

In 2015-16, 2,001 people were admitted formally to a mental health facility in Wales for assessment and/or treatment. This represents an increase of 80 (4 per cent) compared with 2014-15.

Table 1 shows a breakdown of patient admissions to mental health facilities from 2012-13 onwards. Please note that the official statistics were revised by Welsh Government in 2015, following the discovery of a data issue in one of the health boards. As a result, some of the data for 2013-14 in the table below has been revised downwards.

Table 1: Number of patient admissions to mental health facilities, 2012-13 to 2015-16

Legal status	2012-13	2013-14	2014-15	2015-16
Formal admissions	1,453	1,692	1,921	2,001
Informal admissions	8,544	8,582	7,841	7,569
All admissions	**9,997**	**10,274**	**9,762**	**9,570**

Source: Welsh Government Statistics

In 2015-16, formal admissions accounted for 18.7 per cent of all admissions to NHS mental health services and for 86.3 per cent of all admissions to independent mental health hospitals.

While the total number of admissions and informal admissions has fallen for the last three years; formal admissions have increased year on year since 2012-13.

[1] The statistics in this chapter are taken from the official statistics published annually by Welsh Government. As they can be subject to revision, for the latest statistics please refer to the statistics on the Welsh Government’s website. Healthcare Inspectorate Wales will not be revising this report, or previous versions of this annual report, if the official statistics are revised.

Figures for the total admissions to NHS mental health facilities by health board and independent settings are shown in Table 2.

Table 2: Number of patient admissions to mental health facilities by setting (NHS and Independent Mental Health Hospitals), 2015-16

Local Health Board/ Independent Hospital	Number	
	Informal	Formal
Betsi Cadwaladr UHB	1,180	345
Powys Teaching HB	261	62
Hywel Dda UHB	682	220
Abertawe Bro Morgannwg UHB	2,283	247
Cwm Taf UHB	816	409
Aneurin Bevan UHB	1,384	151
Cardiff and Vale UHB	920	296
Independent Hospitals	43	271
Wales	**7,569**	**2,001**

Source: Welsh Government Statistics

For NHS providers in Wales in 2015-16, Cwm Taf University Health Board had the highest number of formal admissions, (409) and accounted for almost one in four of all NHS formal admissions (23.6 per cent). Abertawe Bro Morgannwg University Health Board had the highest number of informal admissions (2,283), which accounted for almost a third (30.3 per cent) of all informal admissions).

2.1 Use of Section 135 and 136 powers – removal of an individual to a place of safety

Sections 135 and 136 of the Mental Health Act give police officers powers in relation to individuals who are, or appear, to be mentally disordered. Police officers may use powers of entry under Section 135 of the Act to gain access to a mentally disordered individual who is not in a public place.

If required, the police officer can remove that person to a place of safety. A place of safety may be a police cell, a hospital based facility or 'any other suitable place, the occupier of which is willing temporarily to receive the patient'

Section 136 of the Act allows police officers to detain an individual who they find in a public place who appears to be mentally disordered and is in immediate need of care or control.

Both Section 135 and Section 136 allow for an individual to be detained in a place of safety for up to 72 hours. During this time period an assessment is undertaken to determine whether hospital admission, or any other help, is required. Section 136 is used significantly more often than Section 135. Table 3 shows the number of uses of Section 135 and 136 in Wales in 2015-16.

Table 3: Completed Mental Health Act assessments in hospital under Section 135 and 136, 2015-16

	Hospital is first and only Place of Safety Detention	Hospital is subsequent Place of Safety Detention after transfer from:			Unknown	Total Assessments
		Another Hospital	Police Station	Another Place		
Section 135	44	0	0	1	0	45
Section 136	1,347	24	108	0	0	1,479

Source: Welsh Government Statistics

For the majority of completed Mental Health Act assessments in hospital under both Section 135 and 136 in 2015-16, a hospital was the first and only place of safety. However, there were 108 completed Mental Health Act assessments in hospital under Section 136 that had been transferred from a police station (seven per cent of the total for Section 136).

2.2 Community Treatment Orders

Community Treatment Orders (CTOs) were introduced in November 2008. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.

Table 4 shows the health board breakdown of people discharged from hospital under a CTO in 2015-16 and Table 5 shows the outcome of those who are subject to a CTO in 2015-16 (numbers include patients from previous years). In 2015-16, there were 216 people discharged from hospital under CTOs in Wales. Of those patients still subject to a CTO in 2015-16, there were 102 recalls to hospital, 86 revocations and 116 discharges.

Table 4: Patients discharged from hospital under Community Treatment Order (CTO), 2015-16

Local Health Board	Legal status prior to CTO		Total
	Section 3	Other sections	
Betsi Cadwaladr UHB	23	0	23
Powys Teaching HB	*	0	*
Hywel Dda UHB	27	*	*
Abertawe Bro Morgannwg UHB	44	*	*
Cwm Taf UHB	18	0	18
Aneurin Bevan UHB	32	*	*
Cardiff and Vale UHB	35	0	35
Wales (a)	**206**	**10**	**216**

(a) Wales totals include patient discharged from independent hospitals under supervised community treatment.
* Figures under 5 have been suppressed to avoid the risk of disclosing information about individuals. Further figures (5 or more) have also been suppressed to avoid secondary disclosure.

Source: Welsh Government Statistics

Table 5: Community Treatment Order (CTO) patient outcome, 2015-16

Local Health Board	CTO related activity				
	Recall	Revocation	Discharge	Assignment to the hospital of a CTO patient	Assignment from the hospital of a CTOI patient
Betsi Cadwaladr UHB	12	11	30	6	9
Powys Teaching HB	0	0	*	*	0
Hywel Dda UHB	18	10	14	5	0
Abertawe Bro Morgannwg UHB	18	16	10	0	0
Cwm Taf UHB	29	20	20	0	0
Aneurin Bevan UHB	19	14	32	5	0
Cardiff and Vale UHB	*	13	*	*	22
Wales (a)	**102**	**86**	**116**	**23**	**40**

(a) Wales totals include patient discharged from independent hospitals under supervised community treatment.
* Figures under 5 have been suppressed to avoid the risk of disclosing information about individuals.

Source: Welsh Government Statistics

3 What we did

3.1 Our role in regard to mental health

HIW has responsibility for the inspection of NHS services, including mental health. It also has responsibility for the registration and inspection of all independent healthcare under the Care Standards Act 2000 and the associated Regulations and the National Minimum Standards.

We do this by undertaking a programme of inspections which provide an overview of care being provided by mental health services, including, where appropriate, specific review of the care of detained patients and implementation of the mental health measure

Since 2009 HIW has also, on behalf of Welsh Ministers, been responsible for monitoring how services discharge their powers and duties in relation to patients detained under the Mental Health Act 1983. We do this by;

- Visiting detained patients in hospital settings and reviewing their care and treatment;
- Providing a registered medical practitioner to authorise and review proposed treatment in certain circumstances (the Second Opinion Appointed Doctor Service);
- Investigating complaints relating to the application of the Act; and
- Producing an annual monitoring report.

3.2 Using intelligence to focus our work

HIW uses intelligence as part of a risk-based approach to influence our work programme. Further information on our risk strategy and our use of intelligence is published on our website http://hiw.org.uk/about/plans/operating/?lang=en.

One key element of the intelligence that we use to focus our mental health work comprises concerns and complaints received from third parties.

In the period 2015-2016 HIW received a total of 324 complaints and concerns via letter, email or telephone either directly or via a third party. Of these, 50 (15%) were in relation to NHS mental health settings and a further 90 (28%) related to independent mental health settings.

In this period, those concerns received related to:

Table 6: Complaints and concerns received relating to mental health services, 2015-16

	NHS	Independent
Whistleblowing	0	3
Patient abuse	4	9
Infrastructure/staffing/facilities/environment	10	32
Consent/communication/confidentiality	3	2
Treatment/Procedure	22	35
Other	11	9

Those concerns were received from a number of sources as set out below;

Table 7: Source of complaints and concerns, 2015-16

	NHS	Independent
Patient	18	32
Relative/Advocate/Other	24	32
Whistleblower	5	20
Staff	3	16

A further source of intelligence are the event notifications that we receive from independent establishments under Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011. Specifically these events are:

- Death of a patient;
- Unauthorised absence;
- Serious injury;
- Outbreak of infectious disease;
- Allegation of misconduct; and
- Deprivation of liberty.

During 2015-16, HIW received 244 notifications of patient safety incidents that occurred within an independent mental health care settings. These were broken down into the following categories:

Table 8: Regulation 30/31 notifications, 2015-16

Serious injury	139
Unauthorised absence of a patient	64
Allegation of staff misconduct	34
Death of a patient	8
Other	4

The information provided on the notifiable event forms enables HIW to assess a healthcare provider's ability to comply with the 2011 Regulations and ultimately that patients are being appropriately safeguarded.

All concerns are assessed by a case manager and recorded as intelligence. The case manager will coordinate as appropriate with relevant agencies including the police, safeguarding boards, coroner and will correspond with the setting to ensure that concerns and incidents are investigated and actions are implemented. Some concerns or incidents may trigger an HIW inspection. Where appropriate concerns at NHS settings can be escalated and action can be taken on regulatory breaches in independent settings in line with our enforcement and non-compliance processes.

3.3 Where we visited

During 2015-16 we conducted 12 inspections of independent establishments and 4 inspections of NHS providers as well as 7 follow-up visits. We also undertook 59 Mental Health Act monitoring ward visits covering 30 hospitals, most of which were undertaken as part of our inspection programme.

In addition, for the first time we started a programme of review for the patients that were subject to Community Treatment Orders (CTO's). We undertook these visits to 3 Health Boards namely; Cwm Taf, Cardiff and the Vale and Aneurin Bevan.

A full list of the health boards and independent registered providers visited is given in Appendix A.

3.4 How we inspect

Engagement of patients and significant others is at the heart of all our inspections. During our visits we engage with as many patients, visitors, relatives and staff as we can.

A range of tools enable the inspectors to examine a number of key areas that impact upon the patient experience including:

- Ward environment;
- Privacy and dignity;
- Overall well- being;
- Food and nutrition;
- Care planning and treatment;
- Medicines;
- Advocacy; and
- Consent to treatment.

Our tools are published on our website to enable easy access to promote and improve patient focused care. These documents are available to organisations, patients, staff, relatives, advocates and any individual with an interest.

The majority of our initial visits take place in the evening where we consider management and leadership amongst a number of issues. Overall our inspections usually last between two and three days. These out of hours visits give an invaluable insight into how the ward operates over a 24 hours.

4 What we found

4.1 Inspections of mental health services

4.1.1 Quality of patient experience

The experience of patients is at the heart of what we do. We use interviews with patients and questionnaire to gather as wide a range of views as possible.

Overall the feedback received from patients was variable, but we generally received positive feedback about the attitude and caring response from the Multi-Disciplinary Team (MDT). Inspectors also frequently observed a positive rapport between patients and staff, despite the sometimes challenging behaviour of some patients.

One of the recurring themes from many of the patients was boredom, with many stating that there was a lack of meaningful and engaging activities. This seemed a particular issue during weekends. In some part this lack of meaningful activity and therapy may be due to a lack of occupational therapy input which was particularly evident in NHS settings.

4.1.2 Delivery of safe and effective care

Physical health care

There were a number of concerning physical health care issues identified across both NHS and independent hospitals. Out of a total of 30 hospitals visited within 11 (36%) of these physical healthcare was an issue including; a lack of adequate weight management, no records of physical observations such as blood pressure and a lack of nutritional assessments. In addition, the documentation of wound care was poor and did not meet an adequate standard to demonstrate effective wound care was being delivered. Diabetic care plans also lacked detail including the monitoring of blood sugars and a structured approach to the managing the complexities of this condition. This lack of detail within individual patient care plans did not assure our inspectors that adequate physical healthcare was being effectively delivered, alongside care for patients' mental health.

There were also deficits in the completion of fluid balance charts for patients where there were concerns about their fluid intake. For some patients we could not be satisfied that patients were sufficiently hydrated.

Some patients had a physical health issue and no plan of care was in place to address this, some examples of conditions where there were no care plans included patients who had a diagnosed urinary tract infection.

During one of our reviews we observed that no physical health care monitoring was documented following an incident of rapid tranquillisation medication. The monitoring of vital signs is essential post rapid tranquillisation and must be conducted as set out in local policies & procedures and in line with the guidance produced by the National Institute for Health & Care Excellence (NICE)

Adequate numbers of staff

In both NHS and independent hospitals we noted a lack of sufficient numbers of staff for the required observational levels and challenging nature of patients being cared for. Out of 30 hospitals visited there were 19 (63%) where we identified shortfalls in the numbers and skill mix of staff This has resulted in a number of issues for patients, specifically:

- Some patients being unable to take section 17 leave;
- Some ward/patient areas not being adequately observed;
- Some patients not receiving regular one to one with their named nurse; and
- Some patients being unable to undertake activities because there was not enough staff available to facilitate these.

A lack of registered nurses and medical practitioners

Across both NHS and independent hospitals there was a shortage of registered nurses and medical staff. This was largely being addressed through the use of agency nurses staff and locum medical staff. Numerous issues were identified with agency nurses including the lack of a documented induction process and the availability of information to confirm that the staff had the necessary skills and knowledge to care for the patient group accommodated. Medical vacancies across some organisations were at very high levels and some strategies were being considered, particularly by health boards, to address this area.

Lack of Psychology & Occupational Therapy

We found a number of examples of a lack of psychology and occupational therapy available for patients in a number of NHS hospitals, although this was not so evident in the independent establishments. This meant that patients who were assessed as benefitting from these therapies did not receive them or there were considerable delays in their provision.

In some instances on particular wards there was no psychology or occupational therapy taking place, clearly this may well have a detrimental effect upon a patients recovery where it has been clearly documented and assessed that these distinct therapies were required.

Training

This year we have continued to identify gaps in staff training across NHS and independent hospitals. Out of 30 hospitals visited a lack of training was identified in 14 (46%). Compliance with mandatory training requirements was better in the independent sector than the NHS. Nearly all the NHS hospitals we have inspected were considered to have poor compliance in a number of training areas, including Mental Capacity Act 2005, Mental Health Act 1983, DoLS and the Mental Health Measure (2010). Clearly these deficits in the knowledge and skills of staff and have a detrimental effect upon patient care.

4.1.3 Quality of management and leadership

A Lack of Available Beds

Within the NHS we found examples of a lack of in-patient beds, this had resulted in some patients travelling many miles from home to receive care. In some hospitals temporary beds were erected in dormitory style bedroom areas with no access to a suitable nurse call system. Other examples were of patients who were on leave needing to go back to the hospital and their beds had been given to another patient and they had to go to a different hospital. Within some Health Boards there was a lack of availability of a range of service provision including low secure and services that enabled a clear pathway for patients rehabilitative care. We noted a lack of strategic planning by Health Boards who needed to address this problem.

Inadequate/lack of essential policies and procedures

In a number of our visits within both NHS and independent hospitals there was a lack of robust policies and procedures that were in line with best practice and NICE guidelines. In addition, some policies had not been reviewed for some time and had passed their proposed review date.

Lack of staff supervision

Within NHS hospitals there were examples of a lack of a supervision system for staff, some disciplines had more comprehensive and regular supervision than others but in terms of nursing staff we found examples of no documented supervision for many years.

There were supervision systems and processes in place for the majority of the independent hospitals, however, the quality, evaluation and effectiveness of the records was variable with some examples containing only a sentence or two.

Maintenance

Maintenance was a common issue with 80% of hospitals visited needing maintenance, refurbishment and replacement of equipment and furniture. This occurred across both the NHS and independent sector. Across NHS hospitals on a number of occasions the lack of response to the reporting of maintenance issues has resulted in significant deterioration of the premises. Concerns we identified included; dirty and unkempt patient areas including patient gardens and courtyards, to more significant issues including structural concerns, requiring major repairs. For a number of years there has been a lack of adequate maintenance of these hospitals and now many wards are in a state of disrepair whilst patients still remain accommodated there.

A lack of a clear admission criteria or its disregard

A particular issue identified with NHS hospitals was the lack of clear admission criteria. In addition, where a criteria existed we found examples where patients were admitted outside of that criteria to an unacceptable environment. Eg: patients admitted with advanced dementia into an acute ward of patients where some were displaying alcohol and drug detoxification.

Care and treatment plan

Within 43% of visits undertaken there were significant issues with patients care and treatment plans and risk assessments. Many plans and risk assessments were out of date and did not reflect the present situation and some patients had risks identified that were not effectively documented along with a strategy for dealing with them. The lack of effective documented evaluation was also an area of concern that was identified

4.1.4 Management issues specific to the independent sector

A Lack of Documentation for Responsible Individual (RI) visits

All independent hospitals are registered with HIW and have to comply with The Independent Health Care (Wales) Regulations 2011. Regulation 28 places a requirement on the owners of an independent hospital to visit a hospital at least every 6 months and prepare a written report on the hospital. A copy of this report must be provided to HIW, Unfortunately a number of hospitals did not have documented reports to confirm that Responsible Individual visits had taken place.

A lack of Registered Managers

It is a requirement under the Independent Health Care (Wales) Regulations 2011 that where the Registered Provider is an organisation a manager must be appointed. All the independent hospitals in Wales belong to an organisation so therefore must have a Registered Manager. The obligation to register as manager falls on the person appointed as the manager.

Unfortunately there are occasions in a significant number of hospitals where there is no Registered Manager because a manager has left and the Registered Provider is in the process of appointing another, and some who have been appointed and are completing the registration process. If a person manages an independent hospital but fails to register with HIW they commit an offence under Section 11 of the Care Standards Act. In addition, in some hospitals there is a high turnover of mangers and this clearly has an impact upon the leadership at the establishment.

4.2 Monitoring the Mental Health Act, 1983 (the Act)

4.2.1 Purpose of the Mental Health Act

The Act protects individual rights of patients who are vulnerable because of their mental health. The Act allows for medical treatment to be administered to individuals who may not consent to it or have the capacity to consent. The accompanying Code of Practice for Wales has been redrafted and the revised version was published in October 2016

The majority of patients who access mental health and learning disability services in Wales are informal and this means that they will receive treatment on a voluntarily basis. However, some informal patients who are 'liable to be detained'[2] can be treated in hospital on a voluntary basis. A third group of patients who may require assessment or treatment can be detained against their will under the Act.

The central purpose of the Act is to ensure that both formal and informal patients receive an appropriate level of care and treatment in an environment that is conducive to their needs and promotes recovery. The key principle is based on treatment, not containment, and to balance risks to the patient and those in society. The Act provides a legal framework to allow for appropriate compulsory medical treatment to be given where is it necessary to the patient's rehabilitation.

The Act gives a range of powers and responsibilities on a number of organisations and individuals including:

- Welsh Ministers;
- Officers and staff of Health Boards, independent hospitals and social Services Departments, whether or not they work in mental health services;
- Police Officers;
- Courts;
- Advocates; and
- The relatives of individuals who maybe subject to the Act.

[2] 'Liable to be detained' is a phrase which refers to individuals who could lawfully be detained but who, for some reason, are not at the present time, Such reason could include, for example, their current co-operation.

The Act is used in a number of diverse environments including:

- Mental health and learning disability wards;
- General medical wards for patients of all ages;
- Other hospitals;
- Accident and Emergency departments;
- Care homes;
- Patients' own homes;
- Courts; and
- Public places.

There are distinct processes that must be adhered too when an individual is being considered for detention. These processes must also be followed when an individual has been detained with either a civil application for admission or a hospital order via the courts. The Act and Code of Practice give safeguards that intend to ensure patients are not inappropriately detained or treated.

5.2.2 How the Act is monitored in Wales

Welsh Ministers have a responsibility to ensure that the Act is lawfully and properly administered throughout Wales and must monitor how services use the Act. Ministers are also required to monitor how services discharge their powers and duties to patients detained under the Act. Patients may be detained in hospital, subject to Community Treatment Orders (CTOs), or guardianship.

This function is undertaken by HIW on behalf of Welsh Ministers who have specific duties that they are required to undertake:

- formulate an annual report;
- provide a registered medical practitioner to authorise and review proposed treatment of patients in certain circumstances;
- keep under review the exercise of the powers of the Act in relation to detained patients and those liable to be detained; and
- investigate complaints relating to the application of the Act;

HIW has undertaken the role of monitoring the Act since April 2009 and this is our seventh annual report. To discharge our duties we have developed robust systems and processes to ensure that our responsibilities are met.

Mental Health Act Visits

HIW utilises the skills and experience of Mental Health Act Reviewers who visit patients who are subject to the Act in locations across Wales. These reviewers have been recruited by HIW for their skills and knowledge of the operation of the Mental Health Act. They consider how effectively Registered Providers and Health Boards discharge their powers and duties towards detained patients.

During their visits our reviewers will assess the environment, the quality and accuracy of the documentation and they will also speak with patients and staff. Their purpose is to establish whether:

- patients' privacy and dignity is being preserved;
- the Code of Practice is being met;
- the necessary policies and procedures in place;
- patients have an effective care and treatment plan that reflects their detained status; and
- patients have access to a range of professional input to ensure appropriate care and treatment including physical healthcare, psychology and occupational therapy.

In most cases these visits are carried out as part of a general inspection and our MHA reviewers will be part of a larger inspection team. However, there will also be occasions when MHA visits are undertaken as stand-alone visit.

During 2015-16 we undertook 59 MHA visits: 3 of these were to specifically monitor patients subject to CTOs. The overall findings reported earlier in this report were relevant to both formal and informal patients. Our specific monitoring of the application of the Act identified the following noteworthy areas:

- good evidence of administrative and medical audit;
- patients well supported to appeal their detention;
- well maintained detention records; and

- very positive feedback about the role of the Approved Mental Health Professionals (AMPH).

We undertook a total of 3 visits to Cwm Taf, Cardiff and the Vale, and Aneurin Bevan health boards where we held interviews and discussions with patients, relatives, advocates and a cross section of staff involved in caring for patients. In all three reviews we found good examples of multi disciplinary team working and decision making. However, we identified issues with completion of documentation including the incorrect use of language when referring to the Act. We also noted that sometimes processes and systems affected the consistency of continuity of the care being provided. In one health board we saw that this led to delays in booking transport for patients and in another health board a lack of a unified electronic system for patient information resulted in delays transferring information between the different organisations involved in caring for patients.

It should be noted that Mental Health Act Administrators have a pivotal role, within all organisations, to ensure the effective monitoring, administration and implementation of the Act. These Administrators had an increasing workload and all Health Boards and Independent Providers of Healthcare must keep this workload under review to ensure the Administrators have sufficient time to undertake this complex role

In addition our monitoring of the application of the Act identified the following areas of concern;

Are adequate records kept?

During a significant number of our visits we identified that there were issues with record keeping including:

- a lack of copies of key documents such as the AMHP reports on patient files;
- a lack of documented information, within the patients notes, that the statutory consultees had discussed the patient with the SOAD; and
- some records were disorganised and difficult to audit even where the appropriate documentation was available .

Where appropriate has consent been obtained and the assessments of capacity been undertaken?

The documented assessment of capacity was difficult to determine when we examined a number of patient records. This is unacceptable given this key area for effective patient care.

Are individuals detained under the Act aware of their rights under Section 132 of the Act?

There was good evidence that patients' rights were explained to them at the time of initial or renewal of detention under the MHA. However, on many hospital wards we could see insufficient evidence that patients' rights were explained to them on a frequent and consistent basis.

Is Section 17 leave managed appropriately?

There were a number of issues identified with the documentation of section 17 leave including:

- a number of expired forms left on patients files that were not clearly identified as expired. This could lead to confusion as to which forms identifying the conditions of the leave were currently in use; and
- lack of essential information on section 17 leave available on individual patients files, eg: Ministry of Justice paperwork for patients detained under section 37[3]

The Second Opinion Appointed Doctor Service (SOAD)

SOADs play an important role in safeguarding individuals who are subject under the Act and promoting their human rights. SOADs are key to ensuring proposed treatment is in the best interest of the patient. The appropriate approved clinician should make a referral to HIW for a SOAD opinion relating to:

- Liable to be detained patients on CTOs (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients;
- Formal and informal patients who are being considered for various serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57);
- Detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58);
- Patients under 18 years of age, whether detained or informal, for whom ECT is proposed, when the patient is consenting having the competency to do so (Section 58A) ; and
- Detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A) .

[3] Section 37 is a hospital order, which is an alternative to a prison sentence.

Once a SOAD request has been received by HIW we aim to ensure that the visit takes place within the following timescales:

- two working days for an ECT request;
- five working days for an inpatient medication request; and
- ten working days for a CTO request.

Our SOAD's continue to find that despite making arrangements to see a patient when they arrive the patient is not available. This clearly has an impact for the patient and their treatment. In addition there continues to be occasions when the Responsible Clinician and Statutory Consultees are unavailable to discuss the treatment with the SOAD, although there has been an improvement in the availability of clinical records/patient notes.

SOADs have a key function in the safeguarding of the rights of patients who are detained under the Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments) Individual SOADs come to their own opinion about the degree and nature of individual patients mental disorder and whether of not the patient has capacity to consent.

A SOAD must be satisfied that the patients' views and rights have been taken into consideration. If they are satisfied the SOAD will issue a statutory certificate which then provides the legal authority for treatment to be given. After careful consideration of the patient and approved clinician's views a SOAD has the right to change the proposed treatment. For example a SOAD may decide to authorise only part of the proposed treatment or limit the number of ECTs given.

In Wales during 2015-16, there were **869** requests for a visit by a SOAD, an increase from 812 in 2014-15. Since 2013-14, the number of requests has risen each year..

Of these:

- 793 requests related to the certification of medication,
- 60 requests related to the certification of ECT,
- 16 requests related to medication and ECT.

The following table provides a breakdown of requests per year:

Table 9: Requests for visits by a SOAD, 2006-07 to 2015-16

Year	Medication	ECT	Both	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690
2014-15	739	68	5	812
2015-16	793	60	16	869

Source: SOAD requests to HIW

6 Conclusion, Recommendations and Next Steps

This report identifies some key issues for Health Boards and for independent providers that must be addressed to give the level of service that patients suffering from a mental illness deserve. Some of the practices and issues identified within the report are unacceptable and it is important that HBs and independent providers have effective governance processes in place to identify issues and address any areas identified.

During our reviews of both NHS and private providers a number of significant issues have been identified by HIW. It is important that providers have robust governance processes in place to identify the issues themselves and take appropriate action. We were concerned to note that around a number key areas including physical healthcare, and care plans and risk assessments for patients, the provider was not aware of the deficits until they were noted by HIW.

HIW continues to work with partnership agencies, HBs and independent providers to improve the patient experience of this very vulnerable patient group.

Recommendations/requirements (requirements for Independent sector only)

Following our findings from our inspections during 2015/16 we have made the following recommendations and requirements (requirements under the regulations are for independent providers only) which the Health Boards and Independent Providers must address in order to deliver a safe and effective service to a vulnerable patient group. Such recommendations will have been included in the individual reports which have been issued to providers following each of our inspections.

Recommendation/requirement	Regulation/standard
Patient experience	
All Health Boards and Independent Providers must ensure that patients have access to a range of meaningful social and recreational activities and that they receive support to participate ion these	Health and Care Standards 1.1, 6.1 and 6.2 Regulation 15 (1) (a) & (b)
Delivery of safe and effective care	
All Health Boards and Independent Providers must ensure that all the physical health care needs of patients are fully assessed and addressed	Health and Care Standards 2.2 , 4.1 and 7.1 Regulation 15 (1) (a) (b) (c) & (d)

All Health Boards and Independent Providers must ensure that all wards have adequate numbers of staff (nursing, medical, psychology and Occupational Therapy) to ensure patients needs are fully met	Health and Care Standard 7.1 Regulation 20 (1) (a)
All Health Boards and Independent Providers must ensure that ALL staff have the necessary training, knowledge and skills to effectively care and treat patients	Health and Care Standard 7.1 Regulation 20 (2) (a) & (b)
Quality of management and leadership	
The Health Boards must ensure that there are sufficient inpatient beds available for potential admissions	Health and Care Standard 2.1
The Health Board and Independent Provider must have effective management and quality assurance systems in place to ensure compliance with the regulations and standards to ensure safe and effective treatment	Health and Care Standards 3.4, 3.5 and 7.1 Regulation 19 (1) (a) & (b) and (2) (a) (b) (c) (d) & (e)
The Health Boards and Independent Providers must ensure that polices and procedures are up to date and reflect current good practice recommendations	Health and Care Standards 2.1, 2.6 and 3.1 Regulation 9 (1)
The Health Board and Independent Providers must ensure that ALL staff receive regular meaningful and documented supervision	Health and Care Standard 7.1 Regulation 20 (2) (a)
The Health Boards must ensure that a comprehensive maintenance programme is in place for ALL its hospitals to ensure that the environments of care are and remain suitable to meet the needs of the patients	Health and Care Standard
The Independent Providers must ensure that the Responsible Individuals are undertaking documented visits that cover the areas listed within Regulation 28 of the regulations	Regulation 28
The Independent Providers must ensure that the individual hospitals have a registered Manager in place	Regulation 11 (1) (a) & (b)
The Health Boards must ensure that there is a clear admission criteria and it is effectively implemented	Health and Care Standard 2.1

The Health Board and Independent Provider must ensure that each patient has a comprehensive risk assessment and care and treatment plan in place	Health and Care Standard 6.1

Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also *independent mental health advocate.*
Accreditation for Mental Health Services (AIMS)	These are standards produced by the Royal College of psychiatrists for inpatient wards.
Appropriate Medical Treatment	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case.
Approved Clinician	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
Approved Mental Health Professional	A professional with training in the use of the Act, approved by a local social services authority to carry out a number of functions under the Act.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over

	is set out in Section 2 of the Mental Capacity Act 2005.
Care Programme Approach (CPA)	The CPA is a co-ordinated system of care management, based on a person centred approach determined by the needs of the individual. There are four key elements within CPA: a systematic assessment that includes identifying needs and assessing risks, the development of a care plan addressing the assessed needs, the appointment of a care coordinator who is a qualified health or social care professional to design and oversee the care plan, and regular reviews as appropriate to evaluate the progress of the care plan.
CO1 form	Certificate of consent to treatment and second opinion (Section 57)
CO2 form	Certificate of consent to treatment (Section 58(3) (a))
CO3 form	Certificate of second opinion (Section 58(3) (b))
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment.
Compulsory treatment	Medical treatment for mental disorder given under the Act
Consent	Agreeing to allow someone else to do something to or for you: Particularly consent to treatment.
Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.

Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as "sectioning" or "sectioned"
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.
Doctor	A registered medical practitioner.
Doctor approved under section 12 (also 'section 12 doctor')	A doctor who has been approved by the Welsh Ministers (or the Secretary of State) under the Act as having special experience in the diagnosis or treatment of mental disorder. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers. Some medical recommendations and medical evidence to courts under the Act can only be made by a doctor who is approved under Section 12. Doctors who are approved clinicians are automatically treated as though they have been approved under Section 12
Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).

HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.
Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS Trust or Health Board) Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.
Hospital order	An order by a court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender, given instead of a prison sentence or other form of punishment. Hospital orders are normally made under Section 37 of the Act.
Human Rights Act **1998**	A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights.
Independent Mental Capacity Advocate **(IMCA)**	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also sometimes known as a voluntary patient.
Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.
Leave of absence	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of

	time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others. Sometimes referred to as *'Section 17 leave'.*
Liable to be detained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time
Local Social Services Authority (LSSA)	The local authority (or council) responsible for social services in a particular area of the country.
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health habilitation, intervention rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental Health Act Commission (MHAC)	The independent body which was responsible for monitoring the operation of the Act. The Health and Social Care Act 2008 abolished the MHAC. Its functions in relation to Wales transferred to the Welsh Ministers who delegated them to Healthcare Inspectorate Wales (HIW).
Mental Health Review Tribunal for Wales (MHRT for Wales)	A judicial body that has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common

	conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Ministry of Justice	Responsible for the Home Office's Mental Health caseworker section along with the public protection caseworker section.
National Institute for Health & Care Excellence (NICE)	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term *'patient'* should be used in practice in preference to other terms such as *'service user', 'client'* or similar. It is simply a reflection of the terminology used in the Act itself.
Place of safety	A place in which people may be temporarily detained under the Act. In particular a place to which the police may remove a person for the purpose of assessment under Section 135 or 136 of the Act. (A place of safety may be a hospital, a residential care home, a police station, or any other suitable place).
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.*
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.
Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49 The order or direction will be imposed on an offender

	where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent
Section 12 doctor	See doctor approved under Section 12.
Section 37	This is an hospital order, which is an alternative to a prison sentence.
Section 41	This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient. Section 41 is a restriction order and is used if a patient is considered a risk to the public.
Section 57 treatment	Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function,
Section 58 & 58A	Section 58 treatments refer to medication for mental disorder and section 58A treatments electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment.
Section 132	This provides a responsibility on the hospital managers to take al responsible steps to ensure all detained patients are given information about their rightss
Section 135	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary remove them to a place of safety

Section 136	Section 136 of the Act allows for any person to be removed to a place of safety if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts; Part 1 – Primary mental health support services Part 2 – Coordination of and care planning for secondary mental health service users Part 3 – Assessment of former users of secondary mental health services Part 4 – Mental health advocacy
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.

Appendix A

Health boards and independent registered providers visited during 2015/16

Health Board	Hospital	Wards
Abertawe Bro Morgannwg University Health Board	Llwyneryr Assessment and Treatment Unit	The hospital comprises one ward that was visited
Abertawe Bro Morgannwg University Health Board	Hafod-y-Wennol Assessment and Treatment Unit	The hospital comprises one ward that was visited
Abertawe Bro Morgannwg University Health Board	Rowan House	The hospital comprises one ward that was visited
Abertawe Bro Morgannwg University Health Board	Cefn-yr-Afon	Ty Ogwr, Ty Garw and Ty Llynfi
Abertawe Bro Morgannwg University Health Board	Princess of Wales, Bridgend	Psychiatric Intensive Care Unit, Wards 14, 15, and 21,
Aneurin Bevan University Health Board	Llanfrechfa Grange Assessment and treatment Unit	The hospital comprises one ward that was visited
Aneurin Bevan University Health Board	Ysbyty Aneurin Bevan	Carn yr Cefn
Aneurin Bevan University Health Board	Maindiff Court	Ty Skirrid and Lindisfarne wards
Betsi Cadwaldar University Health Board	Heddfan	Clywedog, Dyfrdwy, Gwanwyn, Hydref and Treweryn (PICU)
Betsi Cadwaldar University Health Board	Ablett	Tegid, Cynnydd and Dinas,
Betsi Cadwaldar University Health Board	Hergest	Taliesin, (PICU), Cynan and Aneurin
Cardiff and Vale University Health Board	Iorwerth Jones Centre	Coed-y-Felin and Coed-y-Nant
Cwm Taf University Health Board	Ty Llidiard Child and adolescent Unit	Enfys and Seren

Cwm Taf University Health Board	Royal Glamorgan	Admission, wards 21 & 22, Psychiatric Intensive Care Unit, Enhanced Care Area and, Seren
Cwm Taf University Health Board	Pinetree House	Aspen, Rowan and Willow wards
Hywel Dda	Tudor House	The hospital comprises one ward that was visited

Independent provider	**Hospital**	**Wards**
Cambian Healthcare Ltd	Delfryn	Delfryn House, Delfryn Lodge and Rhyd Alyn
Cambian Healthcare Ltd	St Teilo's	Hospital consists of one ward
Coed Du Hall Ltd	Coed Ddu Hall	Ash, Beech and Cedar
Craegmoor Hospitals Ltd	The Priory, Aberdare	The hospital comprises one ward that was visited
Craegmoor Hospitals Ltd	Church Village	The hospital comprises one ward and a self contained bungalow that was visited
Heatherwood Court Limited I	Heatherwood Court	Caerphilly, Cardigan, Chepstow and Caernarvon
Mental Health Care (St David's) Limited	St David's	The hospital comprises one ward that was visited
Mental Health Care (Plas Coch) Ltd	Plas Coch	Morfa and Coachhouse
Partnerships in Care Ltd	Llanarth Court	Awen, Deri, Osbern, Howell, Iddo, Treowen, Teilo and Woodlands Bungalow
Partnerships in Care Ltd	Aderyn	The hospital comprises one ward that was visited
Pastoral Cymru (Cardiff) Ltd	Ty Catrin	Sophia, Victoria, Trelai, Heath and Roath
Priory Group Ltd	Cefn Carnau	Sylfaen, Bryntirion and Derwen
Regis Healthcare Ltd	Regis Healthcare Hospital	Brenin
Rushcliffe Independent Hospitals (Aberavon) Ltd	Rushcliffe Aberavon	The hospital comprises one ward that was visited

NB – The following hospitals listed above were visited twice during 2015/16;

- Delfryn House and Lodge
- Plas Coch
- Hergest